COLORADO
Department of Health Care Policy & Financing

Minutes

State Medical Assistance & Services Advisory Council

303 E. 17th Ave., 7th floor conference rooms 7AB
Denver, CO 80203

June 24, 201
6:00 P.M. – 7:45 P.M.

1. MEDICAL SERVICES BOARD MEMBERS

An Nguyen, (Chair)	Kimberly Jackson	Janet Puglisi
Judy Zerzan	Steve Holloway	Blair Wyles
Jill Atkinson	Ruth O'Brien	Sarah Schumann
Dan Scales	Blaine Olsen, MD	Penny Grande

2. 6:00 Call to Order

3. 6:02 Approval of the minutes from the May 27, 2015 meeting

4. CDASS Audit

Jed Ziegenhagen-

Colorado Medicaid's Consumer Directed Attendant Support Services (CDASS) program. This program functions as a delivery system alternative to traditional skilled and unskilled home care. People under CO Medicaid who meet the Benefits Participation Standard can chose to receive long-term service and support through several vehicles, including nursing homes or the community. Four of the most frequently used community services under the home and community-based services waiver (of which there are 11), contain consumer-directed services as a benefit. In the Medicaid state plan we provide skilled home-health services. People that need those services after an assessment and care-plan process can chose to receive traditional agency-based care (most do) or the alternative that lets people direct their own services. 3,100 are on CDASS, coming to a little under 20% of our clients. This is how it works: in the care-planning process services are priced under a traditional agency based environment, a 10.75% discount is taken off, and that dollar amount is given to the client to manage their own service delivery. This is for services that would otherwise be agency based: personal care, homemaker, and skilled home-health services. The Medicaid client who is participating in Consumer Direction has flexibility in terms of using the allocation. It also comes with responsibilities that clients who are in traditional services don't have to deal with. For example- people who are receiving CDASS are responsible for finding their own attendants, hiring them, training them, and firing them. We have administrative vendors that provide services that are akin to payroll processing and provide training. All LTSS services are authorized by our case-management agencies.

Auditor Recommendations- 1. Recommends that the Department approve oversight of the enrollment requirements process. Specifically, we should have prompts to make sure that case-managers have a check-list to fulfill all requirements. We need to make sure that case managers are adequately trained and have thorough guidance. 2. The Department is obligated to implement contract maintenance procedures to keep a better eye on the administrative contractors that provide the program operational services on the state's behalf. This requires making sure the background checks and nursing license checks are properly completed under state regulations. 3. HCPF is to ensure that funding allocations for clients are based on the client's documented needs and are done in a consistent way across the state. The auditor found that case managers modified and customized the standard forms that the department directed them to use. Data showed that in many cases people deviated from the care plan- both receiving less services so their needs weren't met, and in some cases exceeding the hours allotted. The auditor recommended training for case-managers so they know what to do in those cases when overseeing the process and to strengthen contract management so that when there are procedures in place they are being followed consistently. 4. The last bucket recommends a comprehensive cost-benefit analysis of the program, including looking at other states, improving controls not necessarily identified by the auditor. Based upon that analysis, if necessary the Department is to work with the General Assembly and the centers for Medicare and Medicaid program for changes to the program.

The Department concurred with all recommendations with the exception of the last one. In the Department hearing it was noted that HCPF is and has been conducting a great amount of analysis over this program. It's not a bad idea, but if we implemented it we would need more funding.

Q: Was there a discrepancy between how much money you predicted would be needed vs. how much funding regular home-care clients received? The Home-Care Association is concerned with the discrepancy between what is spent on CDASS and non-CDASS clients.

A: The department's budget is based on PMPM for different categories of clients. Demographically, CO Medicaid clients vary in complexity of care, we have about a dozen different categories in our budget. We don't budget specifically for CDASS. Primarily, CDASS expenditures are contained within the disability eligibility group in our budget which is pretty stable and predictable. There isn't evidence that CDASS cost increases are having an impact on the overall budget. The auditor did look at the cost per person served for agency-based home care vs CDASS. It is true that CDASS patients out-spend traditional agency based home care. What we know from the data is that the populations are not comparable in terms of their needs of the ADL burden, which is what we are paying for very substantially. We have different populations in which the spending isn't the same, and the ADL burden varies, but does the differences in the ADL need explain the cost difference? It is not a question we can answer definitively with the data that we have now.

Q: There has not been an apples to apples comparison between CDASS and home health agency care. How does this audit compare to previous years that you've had one? Are they finding similar things every time they audit?

A: Other audits preformed do show some distinctions. There is a common finding around background checks. The state lacks the business structures and processes to routinely monitor compliance. Training

was another big theme of the audit. The state needs to train the people who administrate payable processes to follow them, and second to provide oversight in terms of data collection of the vendors doing the day to day work.

Q: Are these audit recommendations going to significantly affect those who are enrolled in CDASS?

A: There is not going to be any immediate noticeable change for the people who use CDASS, but there are going to be changes for those who run the program- in the form of background checks, licensing, and operational business process change. Will not spill over into people's experience of service.

5. Accountable Care Collaborative

Judy Zerzan-

We recently did an extension of the Regional Care Collaborative Organization contracts and we plan to re-procure them so the new contracts are in place for July 2017. The ACC partnered with the Program Improvement Advisory Committee, and will have topic-specific stakeholder engagement. The subject-matter specific meetings have begun, the most recent meeting was a few weeks ago and it focused on care coordination, specifically looking for input on contract language. We are hoping to post a calendar of meetings so people can engage where they are most interested. This will be on the website shortly, along with an email address which is open for thoughts and suggestions. A lot of the ideas that are coming both internally and from stakeholders may require additional federal support.

The first major decision made so far is to combine RCCO and Behavioral Health Organizations into a single entity. We will be conducting a procurement process for this new contract, and the organizations need to meet both expectations.

As part of creating a single entity we had to create an integrated organization map. We decided to go with the RCCO map that largely overlaps with the current BHO map with the exception of two counties. We are currently having discussions with these counties about which RCCO they will be in. We have heard a lot of concerns from providers about being split across regions. We are thinking about options for limiting the administrative burden. One option is allowing providers to opt into a region and for their clients to follow them- so it still remains a fundamentally regional approach. We will be seeking more input on this issue.

The final decisions that we announced are around payment- for now we are going to keep physical health predominantly fee-for-service, although we want to think about how we pay the RCCO/BHO combination. We have evolved the RCCO payments quite a bit in the past few years in terms of incentive structures. We have also reduced payment to clients who are not attributed to a primary care medical provider for greater than 6 months. As far as Behavioral health, we will keep it largely capitated for now. We did hear loud and clear that there are current challenges with the system. This may result in gaps in service around early intervention, for those with autism, intellectual and developmental disabilities, and chronic conditions. So we want to focus on how we can change the overall payment model to make it one that supports holistic, integrated, whole-person care.

6. LTSS Policy

Roberta Aceves-

We are amending the SLS draft waiver that went out in January to only include one fiscal management service model. We are going to have just the Fiscal Employer Agency (FEA) model, because we feel that this model will get CMS approval more easily, and we are anxious to get the waiver amendment approved so people with IDD can take advantage of Consumer Direction. Moving forward with the waiver with just the FEA model constitutes a significant change to the one that was put out for public comment so it went out today (June 24th) for public comment again. The entire waiver is published on our website, and the changes we've made since are highlighted. Public comment closes July 31st. The expected rollout date is October 1st.

The other change to this draft amendment is that we are increasing the service rates across the board by 1.7% which was authorized by the General Assembly. When the rates go up by 1.7% the service plan authorization limit will also go up by that amount which happens this fall. The waiver cap will also go up that amount on July 1st, so the new SLS waiver cap will be 46,274 rather than 45,500 that it is currently.

Q: The 46,000 is not inclusive of CDASS correct? CDASS would still be the same, like it is under EBD now?

A: Under the SLS waiver it will work a little bit differently because the personal care and the homemaker services will still have to stay within the person's assessed needs and the waiver cap. The health maintenance will be outside of the cap. The reason for that is because currently it is not in the SLS waiver, and if we included it, people's services would be reduced, and so we are taking it from the state plan and adding it to the waiver so it'll be pretty much a wash with the money transferred.

Q: So the CCBs manage the SLS waiver, what is it going to look like for someone who wants to take advantage of the CDASS option?

A: The CCB case managers will handle all of SLS including the CDASS delivery option. So patients will only have 1 case manager and it will all be under the CCB.

7. Pharmacy Audit

Judy Zerzan-

Prescription Drug Audit- Overall, the audit turned out well. During FY2014 we provided about 5.5 million outpatient prescriptions for just under 500 thousand recipients- at a total cost of 453.2 million. The good part of that is that in FY14 about 85% of the drugs dispensed were generic- which is a high percentage, particularly looking at other states.

We also moved to an average acquisition cost (AAC) for reimbursing prescription drugs a couple of years ago. We survey pharmacies to determine drug costs, and we then supply that data to a contractor who looks at the data in comparison to national and local pricing indicators in order to give an average reimbursement as close to cost as possible.

When we changed to the AAC we also did a change in dispensing fee to fairly reimburse for the work that goes into filling prescriptions. For a long time our dispensing fee for prescriptions was $4. We did a survey of the salaries, utilities, and other associated costs, and we made the fee a range based on volume, somewhere between $9 and $13. Additionally, there are only a handful that qualify as rural pharmacies, which is defined as being 30 miles away from any other pharmacy. For those, the dispensing fee is around $13, to reflect the challenges of accommodation. The auditors found that this new way of reimbursing created an average savings of $14 per recipient, or about $5.7 million annually.

The auditor had four main cost findings- 1) Over the course of two years we paid for 5,154 prescription claims that did not have approval to be dispensed. These payments were question costs which totaled about 1.1 million for those little over 5,000 drugs. Those costs fell into two categories: one were things that should have had prior authorizations that didn't. Part of why the prior authorizations didn't happen is based on how we set them, based on an NDC (national drug code) which changes a lot. We get information from a national contractor source but have realized through this audit that it is not 100% correct. Another reason is that a lot of drugs have recently changed from prescription to over the counter- some of which we've missed in this process. Finally, we allow emergency fills for 72 hours' worth of supply, and a pharmacist needs to get approval on those, however some pharmacists used a code that allowed them to put in the approval without authorization.

2) Two findings were about opiates, and findings of not having adequate controls, and over-utilization. The auditor identified 17 individual recipients who greatly exceeded the over-utilization criteria. Our rules for people who are over-utilizing say that we put them in a lock- in program so they can only use one pharmacy and one provider. Unfortunately a couple of years ago we put that rule on hold because we couldn't change our MMIS system to lock clients into providers. We are now working on implementing that program. On the provider side of things they identified 492 providers whose prescribing patterns were a concern. They looked at the OIG criteria to determine this. The criteria identifies you as over-prescribing if: 1. You wrote more than 400 prescriptions of schedule 2 or 3 opiates in a year. 2. If you prescribed opiates for more than 200 patients, 3. If you prescribed more than 12 opiate prescriptions per patient and/or 4. If 75% of your prescription drug claims were for opiates. It would be pretty easy at a primary care practice to reach some of those criteria in normal practice. An average panel size for primary care can be a couple thousand so 200 people to give an opiate to is not a lot.

3). The last finding is that the Department paid $67,200 for just over 2,000 prescriptions for providers who had been excluded or terminated from serving Medicaid recipients. We particularly agreed with the finding about the providers who had been terminated from seeing Medicaid clients; we've known about it, but it is a difficult fix in our current MMIS system. Those things are currently being built into the new system, so almost all of the findings will be corrected in November 2016 when we roll out the new system.

Q: Do the pharmacies who have been prescribing unauthorized drugs get a letter or a visit?

A: We had reached out to them prior to let them know this is not how they do things, and we changed the code so it will no longer work to override things.

8. Vice Chair Election

Mark Thrun has stepped down as Vice Chair. Dan Scales volunteered in his place, without opposition. Dan was nominated, which was then moved to a vote, seconded, and passed unanimously. Congratulations Dan, on your new role as Vice Chair!

9. Department Updates

Judy Zerzan-

There is a new SIM website and new SIM committees and public meetings are going to begin shortly. Here is a copy of the link-https://www.colorado.gov/healthinnovation

The Opportunity Project – This project focuses on how to get people to middle class by middle age, and we are now expanding our focus beyond middle age. We put out a request for examples of evidence based programs that could fit in to each of those life stages. We have included this work in the RCCO contracts that are going into effect July 1st, requiring each RCCO to hire an opportunity project person. We are asking that their initial focus be on the family formation, and early childhood life stages. We also recently got approval for a health and aging policy fellow- a fellowship sponsored by Atlantic Philanthropies. Typically these fellows go to DC, but we are lucky enough to get one and her name is Dr. Hillary Lum. She is a geriatrician out at the University of Colorado and she is going to help us develop what happens after age 40, because our current framework ends at 40. We will be thinking about what are the quality metrics, goals, and relevant programs, and starting a stakeholder process. We're thinking the next age categories after 40 are 40-65 because things change when Medicare and retirement become factors. The next categories will be ages 65-85 and 85+. Hillary will be working on that starting this fall and we are very excited about that.

10. Round Robin

Penny Grande-

Joining SMASAC in the public role- I come from the Tri County Health Department. I am the associate director of nursing. I've been with the department about 14 years. We work with Medicaid, and have access to care. We are working on our relationship with the RCCOs and we have Colorado access.

Sarah Schumann-

I'm at Brookside Inn- a skilled nursing facility located in Castle Rock and I'm representing skilled nursing.

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